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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual recertification survey conducted at your facility from 10/7/08 through 10/10/08. The census at the time of the survey was 38. Fourteen records including one closed record were reviewed. Complaint #NV19380 was unsubstantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to observe personal privacy for 3 of 14 residents (#6, #13, #14).

Findings include:

Observation

On 10/9/08 at 9:10 AM, while interviewing Resident #6 in her room, a Certified Nursing Assistant (CNA) walked into the room without knocking and waiting to be invited in.

On 10/9/08 at 9:40 AM, the same CNA walked into the room without knocking. "I'm just checking on my patients," she said.

On 10/9/08 at 3:40 PM, a resident was calling, "Oh, oh, oh," repetitively from Resident #13's room. The Director of Nursing (DON) walked into the room without knocking.

On 10/10/08 at 7:35 AM, the medication nurse walked into the room of Resident #14 without

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F 164	Continued From page 2 knocking. Interview When asked about the CNA walking in without knocking, Resident #6 replied, "It happens all the time . . . I wish they would knock first."	F 164		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide care in a manner that promoted and maintained dignity for 3 of 14 residents (#11, #15, #16). Observation On 10/9/08 during the lunch meal in the Dining Room, two CNAs (Certified Nurses Assistant) were seated at one table assisting three residents. One CNA was feeding two residents at the same time. The CNA placed a spoonful of food in Resident #15's mouth with her right hand and fed Resident #16 with her left hand. Resident #16 was seated between the same two CNAs and both CNAs fed Resident # 16. On 10/10/08 in the morning, a Physical Therapy Assistant (PTA) provided wound care to Resident #11 in the resident's room. Resident #11 remained seated in his wheelchair and the PTA	F 241		

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F 241	Continued From page 3 prepared to change the dressing while she was seated on the floor. The door to the room was left open and the curtain was not pulled. The resident was visible from the hallway. Interview The PTA acknowledged that the door should be closed to maintain the resident's privacy during the dressing change.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive care plans were	F 279		

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F 279	Continued From page 4 established for 2 of 14 residents (#8, #11). Findings include: Resident #8 The resident had a date of birth of 10/1/1919 and an admission date of 6/19/08. Record Review 1. The Physician's Orders documented: - Lortab (7.5/500) was prescribed on 6/19/08 PRN (as needed) every 8 hours (Q 8) for pain. - On 6/24/08 the order was changed to 7.5/325 TID (three times per day). - On 6/27/08 Lortab 7.5/325 PRN Q 8 for breakthrough pain. - The order was clarified to Lortab 7.5/500 TID and Lortab 7.5/500 Q8 PRN - On 8/11/08 the PRN was increased to 10/500 PRN Q 6 hour. - On 10/10/2008 (during the survey), the Lortab order was changed to 10/500 TID for chronic pain and Lortab 10/500 PRN Q 6 for breakthrough pain. 2. "Pain" was not listed on the care plan as a problem area. 3. The Pain Assessment Form stated "chronic pain in right hip." Interview On 10/10/08, in the morning, the DON (Director of Nursing) confirmed "pain" was not listed on Resident #8's care plan. The DON indicated "pain" was an item the facility should care plan.	F 279		

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Resident # 11

Resident #11 was admitted on 7/29/08, with diagnoses including Seizure Disorder, Multiple Sclerosis, Hypertension and Deep Vein Thrombosis.

Record Review

On 7/29/08, The Braden Scale for Predicting Pressure Sore Risk identified Resident #11 had a high risk for developing pressure sores.

The initial Minimum Data Set (MDS) dated 8/7/08, triggered the Resident Assessment Protocol (RAP) for care plan interventions for skin breakdown.

The care plan for Resident #11 lacked interventions for potential skin breakdown based on the initial MDS and The Braden Scale for Predicting Pressure Sore Risk, which both revealed the resident had a high potential for skin breakdown.

On 9/12/08, the records indicated the resident had developed a 2 by 5 centimeter blister on his right heel.

No care plan interventions were documented for the blister on Resident #11's heel. Interventions were not documented in the care plan until 10/08, when the blister was documented as an unstageable wound.

Interview

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F 279	Continued From page 6 On 10/10/08 in the morning, the Director of Nursing (DON) indicated Resident #11 was predisposed to skin breakdown based on his medical condition. She further indicated that based on the initial The Braden Scale for Predicting Pressure Sore Risk and the RAPs, care plan interventions should have been in place to prevent skin breakdown.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the facility failed to evaluate the results of interventions for medications taken on an as needed basis for 1 of 14 residents (#9). Findings include: Resident #9 Resident #9 was a 55 year-old male, admitted to the facility on 6/1/08, with diagnoses including Delusional Disorder, Left-sided Hemiparesis status post Cerebrovascular Accident, Diabetes Mellitus, Hypertension and Arthritis. Record Review Resident #9 had the following orders for the	F 309		

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month of September, 2008:

1) Soma 350 milligrams by mouth three times a day as needed for stiffness;
2) Tylenol 650 milligrams by mouth every 4 hours as needed for pain or temperature over 101;
3) Lortab 10/500 milligrams by mouth every 6 hours as needed for headache;
4) Milk of Magnesia 30 cc (cubic centimeters) by mouth every day as needed for constipation;
5) Maalox 30 cc by mouth every 4 hours as needed for indigestion; and
6) Dulcolax 5 milligrams by mouth every day as needed for constipation.

The September 2008 medication administration record (MAR) and as needed (PRN) Record indicated the following:

1) Soma was given for stiffness 16 times. The PRN Record lacked documented evidence of the results for 11 of 16 doses of Soma given.

2) Tylenol was given 6 times for pain. The PRN Record lacked documented evidence of the results for 2 of 6 doses of Tylenol given.

3) Lortab was given 16 times for pain. The PRN Record lacked documented evidence of the results for 13 of 16 doses of Lortab given.

4) Milk of Magnesia was given 12 times for constipation. The times and dates of ten doses given were recorded on the PRN Record. The PRN Record lacked documented evidence of results for 9 of 12 doses Milk of Magnesia given.

5) Maalox was given once for indigestion. The PRN Record lacked documented evidence of

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F 309	Continued From page 8 Maalox being given. The PRN Record lacked documented evidence of results for the dose of Maalox. 6) Dulcolax was given seven times for constipation. The times and dates of six doses given were recorded on the PRN Record. The PRN Record lacked documented evidence of results for 5 of 7 doses of Dulcolax given. Document Review According to the facility's Policy and Procedure for Medication Administration, effective 3/15/06 and revised 4/18/08, "The results must be documented for pain meds, laxatives, etc." Interview On 10/10/08 in the morning, the Director of Nursing (DON) indicated the medication nurse should have documented each time the medication was given as well as the results (effectiveness) of the PRN medications.	F 309		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		

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given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure adequate monitoring of drug regimens for 3 of 14 residents (#1, #3, #6).

Findings include:

Resident #3

The resident had a DOB (date of birth) of 4/3/1956. Her diagnoses included: Congenital Hip Dysplasia; Learning Disability; Symptomatic Anxiety with Cognitive Disorder (added 10/1/07).

Record Review

1. A physician's order written on 9/4/07 read, "Xanax 0.25 mg (milligrams) every 8 hours PRN (as necessary)." The Xanax was ordered due to "the patient's mother passed away 9/07."

2. The diagnosis for the justification of the Xanax was added on 10/1/07 (Anxiety with cognitive disorder).

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3. The PRN Medication Administration Record (MAR) revealed the following:

9/08
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.
The reason for administering listed "patient request" for the 1st, 2nd, 3rd, 5th, 6th, 7th, 11th, 13th, and 14th.
No reason was given for the 30th.
Other reasons were listed as "anxiety" or "for sleep."

8/08
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.
The reason for administering listed "patient request" for the 3rd, 21st, 24th (3 times), 25th, 27th, and 30th.
The MAR revealed Resident #3 received the medication every day of the month except for the 20th, 28th, and 29th. The MAR also revealed she received the medication 2 times on the 18th and 3 times on the 26th.
Other reasons were listed as "anxiety" or "for sleep."

7/08
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.
The reason for administering listed "patient request" for the 9th, and 24th.
The MAR revealed Resident #3 received the medication every day of the month except for the 5th, 8th, 27th and 29th. The MAR also revealed she received the medication 2 times on the 1st,

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2nd, 3rd, 4th, and 8th and administered 3 times on the 16th.
Other reasons were listed as "anxiety" or "for sleep."

6/08
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.
The MAR revealed Resident #3 received the medication every day of the month except for the 7th. The MAR also revealed she received the medication 2 times on the 3rd, 4th, 5th, 6th, 10th, 13th, 18th, 24th, 25th, 26th, 27th, and 28th and administered 3 times on the 19th and 20th.
Other reasons were listed as "anxiety" or "for sleep."

5/08
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.
The reason for administering listed "patient request" for the 4th, 7th, 8th, and 26th.
The MAR revealed Resident #3 received the medication every day of the month except for the 11th, 12th, 14th, and 17th. The MAR also revealed she received the medication 2 times on the 8th, 25th, 30th and 31st and administered 3 times on the 26th.
Other reasons were listed as "anxiety" or "for sleep."

4/08
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.
The reason for administering listed "patient request" for the 6th. "Per family request" on

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4/7/08.
The MAR revealed Resident #3 received the medication every day of the month except for the 5th, 8th, 27th and 29th. The MAR also revealed she received the medication 2 times on the 1st, 2nd, 3rd, 4th, and 8th and administered 3 times on the 16th.
Other reasons were listed as "anxiety" or "for sleep."

3/08
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.
The reason for administering listed "patient request" for the 30th.
The MAR revealed Resident #3 received the medication every day of the month except for the 28th.
Other reasons were listed as "anxiety" or for sleep/helps rest.

2/08
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.
The MAR revealed Resident #3 received the medication every day of the month.
Reasons were listed as "anxiety" or "for sleep."

1/08
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.
The reason for administering listed "patient request" for the 6th.
The MAR revealed Resident #3 received the medication every day of the month except for the 13th, 26th, and 30th.

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Other reasons were listed as "anxiety" or "for sleep."

12/07
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.
The MAR revealed Resident #3 received the medication every day of the month
Reasons were listed as "anxiety."

11/07
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.
The MAR revealed Resident #3 received the medication every day of the month .
Reasons were listed as "anxiety", "helps sleep."

10/07
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.

9/07
No "alternatives tried" was documented for the entire month.
No attempt of reduction was documented.
Reasons were listed as "grieving/sad."

4. Pharmacy reviews were recorded monthly:

-The first attempt to reduce the Xanax was in the 9/26/08 pharmacy report - "Her current Xanax order is 0.25mg Q8 hour PRN. Could we consider trial decrease to 0.125mg Q8 PRN?"

- "No new irregularities" were documented for pharmacy reviews dated 10/26/07, 9/2/08,

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F 329	Continued From page 14 7/23/08, 7/2/08, 6/2/08, 4/30/08, and 3/31/08. - The 1/28/08 pharmacy report stated "Nurses only: need to document what was tried or given prior to giving Xanax." -The 12/17/07 pharmacy report stated "Nurse only: need to comment on the effect of giving Xanax and what anxiety she is having. Xanax was prescribed when a family member passed away. Perhaps, she still needs but we need to document her anxiety." - The 9/29/07 pharmacy report stated "...anxiolytic agents be used only when evidence exists that other possible reasons for distress have been considered....Please indicate the appropriate diagnosis...in the resident's chart." 5. The care plan (7/08 review date) listed #17's problem as "...has a PRN order for the antianxiety medication Xanax and is at risk for the adverse side effects associated with this medication." The Approaches stated "observe for adverse side effects such as insomnia, irritability, dizziness, etc.." Interview On 9/10/08 in the morning, the DON (Director of Nursing) indicated the staff should have been offering and documenting alternative methods tried and should have been explicit in the reason Xanax was needed. The DON confirmed "per patient request" was insufficient. Resident #6	F 329		

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Resident #6 was a 93 year-old female, admitted on 2/9/07, with diagnoses including Metastatic Ovarian Cancer, Depression and Constipation.

Record Review

Resident #6 had a physician's order and was receiving Timolol Maleate eye drops and Xalatan eye drops. There were no diagnoses in the record indicating a need for these medications.

Interview

On 10/10/08 in the morning, the DON confirmed there were no diagnoses in the chart for these two medications, stating, "She was on them when she was admitted."

Resident #1

Resident #1 was a 74 year-old female, admitted on 4/11/08, with diagnoses including Advanced Alzheimer's, Diabetes, Hypertension, Coronary Artery Disease and Transient Ischemic Attack. The resident had been on Risperdal in the past but this medication was discontinued in July 2008. Risperdal was reordered on 9/18/08 without a diagnosis or clinical indications.

Record Review

A physician's telephone order was received on 9/18/08 for Risperdal 0.5 milligrams bid (twice a day).

Consultation Report from Resource Pharmacy dated September 26, 2008 indicated that antipsychotic medications should only be used

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with specific psychiatric diagnoses and clinical conditions. The Pharmacy recommendation was for the physician to include the diagnosis and condition for which the patient was being treated. The attending physician had not addressed the pharmacy recommendations or signed off that he had reviewed the recommendations.

Physician progress notes did not document clinical indications for psychotropic medications:

- 8/24/08 "No complaints, Vital signs stable, Heel Ulcer."
- 9/28/08 - "No complaints. Stable."

Nurses notes documented several falls prior to the order for Risperdal but no supporting clinical indications for psychotropic medications. Documentation included:

- 9/10/08 1348 (1:48 PM) - "Resident found lying on floor on bedmat on lt (left) side by CNA."
- 9/11/08 0541 (5:41 am) - "Pt (Patient) found lying on mat on the floor next to her bed."
- 9/18/08 1826 (6:26 PM) - "...a loud noise heard in bathroom, resident found laying on floor on right side in shower."

Medication Administration Record (MAR) revealed Resident #1 had been receiving Risperdal 0.5 milligrams twice a day since 9/18/08 as physician ordered.

Interview

On 10/12/08 in the morning, the LPN (Licensed Practical Nurse) stated that Resident #1 was restarted on Risperdal due to her repetitive comments and movements and was not sleeping

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F 329	Continued From page 17 well at night. The LPN stated that following the pharmacy review, the pharmacist's recommendations were faxed to the attending physician. If there was no response from the physician within a couple of weeks, the nurse would refax the recommendations.	F 329		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the facility failed to ensure no significant medication errors occurred for 1 of 14 residents (#11). Findings include: Resident #11 Resident #11 was a 55 year-old male, admitted to the facility on 6/1/08, with diagnoses including Delusional Disorder, Left-sided Hemiparesis status post Cerebrovascular Accident, Diabetes Mellitus, Hypertension and Arthritis. Record Review On 10/8/08 at 7:45 AM, the clinical record contained a physician's telephone order, dated 10/4/08 at 10:00 PM, to "Stop Levaquin. Start Bactrim DS (double strength) 1 by mouth twice a day for 10 days."	F 333		

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F 333	Continued From page 18 According to the October 2008 medication administration record (MAR), Resident #11 received Bactrim DS at 8:00 AM and 5:00 PM on October 5. The documentation on the MAR indicated the resident had not received Bactrim twice a day for 3 days in a row (10/6, 10/7 and 10/8/08). Document Review The Policy and Procedure, dated 7/07, indicated, " . . . The completed form is then faxed to the pharmacy immediately for the delivery of the ordered medication and new replacement emergency kit. The physician's order should also be faxed to the pharmacy . . ." Interview On 10/9/08 at 10:45 AM, the licensed practical nurse (LPN) who was passing medications explained the medication had not been delivered by the pharmacy as of 10/8/08. A second LPN presented two different completed medication requests that had been faxed to the pharmacy. There were no fax confirmation sheets. On 10/9/08 at 3:55 PM, the DON was present as a second LPN indicated she called the pharmacy on 10/6 and stated, "They said they would send it that day." The second LPN indicated she did not notify the physician when Resident #11 did not receive the medication twice a day on 10/6, 10/7 and 10/8/08.	F 333		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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F 431	Continued From page 19 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to dispose of medications and feeding supplements on or before their expiration date(s). Findings include:	F 431		

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F 431	Continued From page 20 Observation On 10/9/08 at 9:45 AM, a dose of intravenous Cipro 400 milligrams with an expiration date of 9/08 was in the "Emergency IV (intravenous) Kit" in the medication room. On 10/9/08 at 9:50 AM, there were 7 cans of Jevity feeding supplement (250 calories in 250 milliliters (ml)) with an expiration date of 7/1/08 in the clean utility room. On 10/9/08 at 9:50 AM, there were 6 cans of Glucerna (237 calories in 250 ml) with an expiration date of 9/1/08 in the clean utility room. On 10/9/08 at 10:00 AM, there was a tube of Anbesol ointment with an expiration date of 4/07 in the medication cart. On 10/9/08 at 10:00 AM, there was tube of triple antibiotic ointment with an expiration date of 8/08 in the medication cart. Interview On 10/9/08, the medication nurse acknowledged the medications and feeding supplements should have been disposed of by their (respective) expiration dates.	F 431		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in	F 441		

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the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure appropriate disinfecting techniques to prevent the transmission of infection for 1 of 14 residents (#11).

Findings include:

Observation

On 10/10/08 at 10:30 AM the Physical Therapy Assistant (PTA) administered wound care to Resident # 11's right heel using a portable Ultrasound (US) machine. The PTA removed the soiled dressing from the Resident's right heel. The wound was approximately 2 inches in circumference with black eschar.

The PTA changed gloves and placed a thin, clear barrier (hydroscan) over the wound and began the Ultrasound treatment. The PTA held the resident's leg with her left gloved hand and held the wand of the Ultrasound machine in her right gloved hand. She moved the wand around the outer circumference of the wound for 5 minutes.

Upon completion of the US treatment, the PTA wiped off only the soundhead of the US machine with an alcohol swab wearing the same gloves used during the wound care. The PTA did not disinfect the US wand or cord that that had touched the floor. The wand was returned to the

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undercarriage of the US machine to be used for another treatment.

The PTA removed the hydroscan and applied a new dressing to the wound wearing the same soiled gloves. The PTA then picked up the garbage which included the soiled dressing. While still wearing the same gloves. the PTA pulled the Ultrasound machine out of the resident's room down the hallway to the Utility Room. The PTA disposed of the garbage, removed her gloves and washed her hands. The PTA proceeded to pull the US machine back to the PT area for future use.

The US machine was not disinfected at any time.

Interview

On 10/10/08 in the afternoon, the Physical Therapist stated that when the Ultrasound machine is used in a resident's room, it should be disinfected with an alcohol swab including the tip of the wand, the entire wand and the machine if it is "contaminated", which would be based on the PTA's judgement.

Document Review

Review of the Policy #602.0 - Subject: Wound Care - Ultrasound dated 5/24/01 and initialed 8/05, revealed:

- Apply personal protective equipment
- Remove and discard dressings in red bag
- Remove electrodes. Remove jell and/or hydroscan, disinfect sound head.
- Cover wound using sterile technique and inform nursing to apply prescribed dressing.

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F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that staff wash their hands after direct patient contact. Findings include: On 10/8/08 in the morning, observation of the breakfast meal in the residential Dining Room revealed a CNA feeding a resident. The CNA then fed another resident without washing her hands.	F 444		